

House Study Bill 25 - Introduced

HOUSE FILE _____

BY (PROPOSED COMMITTEE ON
HUMAN RESOURCES BILL BY
CHAIRPERSON FRY)

A BILL FOR

1 An Act relating to programs and activities under the purview
2 of the department of public health, and including effective
3 date provisions.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 DIVISION I

2 PROGRAM FLEXIBILITY AND EFFICIENCIES

3 Section 1. Section 125.59, subsection 1, paragraph b, Code
4 2017, is amended to read as follows:

5 b. If the transferred amount for this subsection exceeds
6 grant requests funded to the ten thousand dollar maximum, the
7 Iowa department of public health may use the remainder for
8 activities and public information resources that align with
9 best practices for substance-related disorder prevention or to
10 increase grants pursuant to subsection 2.

11 Sec. 2. Section 135.11, subsection 31, Code 2017, is amended
12 by striking the subsection.

13 Sec. 3. Section 135.150, subsection 2, Code 2017, is amended
14 to read as follows:

15 2. The department shall report ~~semiannually~~ annually to the
16 general assembly's standing committees on government oversight
17 regarding the operation of the gambling treatment program.
18 The report shall include but is not limited to information on
19 the moneys expended and grants awarded for operation of the
20 gambling treatment program.

21 DIVISION II

22 MEDICAL HOME AND PATIENT-CENTERED HEALTH ADVISORY COUNCIL

23 Sec. 4. Section 135.159, Code 2017, is amended by striking
24 the section and inserting in lieu thereof the following:

25 **135.159 Patient-centered health advisory council.**

26 1. The department shall establish a patient-centered health
27 advisory council which shall include but is not limited to
28 all of the following members, selected by their respective
29 organizations, and any other members the department determines
30 necessary:

31 a. The director of human services, or the director's
32 designee.

33 b. The commissioner of insurance, or the commissioner's
34 designee.

35 c. A representative of the federation of Iowa insurers.

- 1 *d.* A representative of the Iowa dental association.
- 2 *e.* A representative of the Iowa nurses association.
- 3 *f.* A physician and an osteopathic physician licensed
- 4 pursuant to chapter 148 who are family physicians and members
- 5 of the Iowa academy of family physicians.
- 6 *g.* A health care consumer.
- 7 *h.* A representative of the Iowa collaborative safety net
- 8 provider network established pursuant to section 135.153.
- 9 *i.* A representative of the Iowa developmental disabilities
- 10 council.
- 11 *j.* A representative of the Iowa chapter of the American
- 12 academy of pediatrics.
- 13 *k.* A representative of the child and family policy center.
- 14 *l.* A representative of the Iowa pharmacy association.
- 15 *m.* A representative of the Iowa chiropractic society.
- 16 *n.* A representative of the university of Iowa college of
- 17 public health.
- 18 2. The patient-centered health advisory council may utilize
- 19 the assistance of other relevant public health and health care
- 20 expertise when necessary to carry out the council's purposes
- 21 and responsibilities.
- 22 3. A public member of the patient-centered health advisory
- 23 council shall receive reimbursement for actual expenses
- 24 incurred while serving in the member's official capacity
- 25 only if the member is not eligible for reimbursement by the
- 26 organization the member represents.
- 27 4. The purposes of the patient-centered health advisory
- 28 council shall include all of the following:
- 29 *a.* To serve as a resource on emerging health care
- 30 transformation initiatives in Iowa.
- 31 *b.* To convene stakeholders in Iowa to streamline efforts
- 32 that support state-level and community-level integration and
- 33 focus on reducing fragmentation of the health care system.
- 34 *c.* To encourage partnerships and synergy between community
- 35 health care partners in the state who are working on new

1 system-level models to provide better health care at lower
2 costs by focusing on shifting from volume-based to value-based
3 health care.

4 *d.* To lead discussions on the transformation of the
5 health care system to a patient-centered infrastructure that
6 integrates and coordinates services and supports to address
7 social determinants of health and to meet population health
8 goals.

9 *e.* To provide a venue for education and information
10 gathering for stakeholders and interested parties to learn
11 about emerging health care initiatives across the state.

12 *f.* To develop recommendations for submission to the
13 department related to health care transformation issues.

14 Sec. 5. Section 136.3, subsection 13, Code 2017, is amended
15 to read as follows:

16 13. Perform those duties authorized pursuant to ~~sections~~
17 section 135.156 and 135.159 and other provisions of law.

18 Sec. 6. Section 249N.2, subsections 15 and 19, Code 2017,
19 are amended to read as follows:

20 15. "*Medical home*" means ~~medical home as defined in~~
21 section 135.157, a team approach to providing health care that
22 originates in a primary care setting; fosters a partnership
23 among the patient, the personal provider, and other health care
24 professionals, and where appropriate, the patient's family;
25 utilizes the partnership to access and integrate all medical
26 and nonmedical health-related services across all elements of
27 the health care system and the patient's community as needed by
28 the patient and the patient's family to achieve maximum health
29 potential; maintains a centralized, comprehensive record of all
30 health-related services to promote continuity of care; and has
31 all of the following characteristics:

32 *a.* A personal provider.

33 *b.* A provider-directed team-based medical practice.

34 *c.* Whole person orientation.

35 *d.* Coordination and integration of care.

1 e. Quality and safety.

2 f. Enhanced access to health care.

3 g. A payment system that appropriately recognizes the added
4 value provided to patients who have a patient-centered medical
5 home.

6 19. "*Primary medical provider*" means the personal provider
7 ~~as defined in section 135.157~~ trained to provide first contact
8 and continuous and comprehensive care to a member, chosen by
9 a member or to whom a member is assigned under the Iowa health
10 and wellness plan.

11 Sec. 7. Section 249N.2, Code 2017, is amended by adding the
12 following new subsection:

13 NEW SUBSECTION. 17A. "*Personal provider*" means the
14 patient's first point of contact in the health care system
15 with a primary care provider who identifies the patient's
16 health-related needs and, working with a team of health
17 care professionals and providers of medical and nonmedical
18 health-related services, provides for and coordinates
19 appropriate care to address the health-related needs
20 identified.

21 Sec. 8. Section 249N.6, subsection 2, paragraph c, Code
22 2017, is amended to read as follows:

23 c. The department shall develop a mechanism for primary
24 medical providers, medical homes, and participating accountable
25 care organizations to jointly facilitate member care
26 coordination. The Iowa health and wellness plan shall provide
27 for reimbursement of care coordination services provided
28 under the plan ~~consistent with the reimbursement methodology~~
29 ~~developed pursuant to section 135.159.~~

30 Sec. 9. Section 249N.6, subsection 3, paragraph a, Code
31 2017, is amended to read as follows:

32 a. The department shall provide procedures for accountable
33 care organizations that emerge through local markets to
34 participate in the Iowa health and wellness plan provider
35 network. Such accountable care organizations shall incorporate

1 the medical home ~~as defined and specified in chapter 135,~~
2 ~~division XXII,~~ as a foundation and shall emphasize whole-person
3 orientation and coordination and integration of both clinical
4 services and nonclinical community and social supports that
5 address social determinants of health. A participating
6 accountable care organization shall enter into a contract with
7 the department to ensure the coordination and management of the
8 health of attributed members, to produce quality health care
9 outcomes, and to control overall cost.

10 Sec. 10. REPEAL. Sections 135.157 and 135.158, Code 2017,
11 are repealed.

12 DIVISION III

13 WORKFORCE PROGRAMMING

14 Sec. 11. Section 84A.11, subsection 4, Code 2017, is amended
15 to read as follows:

16 4. The nursing workforce data clearinghouse shall be
17 established and maintained in a manner consistent with the
18 health care delivery infrastructure and health care workforce
19 resources strategic plan developed pursuant to section ~~135.164~~
20 135.163.

21 Sec. 12. Section 135.107, subsection 3, Code 2017, is
22 amended to read as follows:

23 3. The center for rural health and primary care shall
24 establish a primary care provider recruitment and retention
25 endeavor, to be known as PRIMECARRE. The endeavor shall
26 include a health care workforce and community support grant
27 program, and a primary care provider loan repayment program,
28 ~~and a primary care provider community scholarship program.~~
29 The endeavor shall be developed and implemented in a manner
30 to promote and accommodate local creativity in efforts to
31 recruit and retain health care professionals to provide
32 services in the locality. The focus of the endeavor shall
33 be to promote and assist local efforts in developing health
34 care provider recruitment and retention programs. The center
35 for rural health and primary care may enter into an agreement

1 under chapter 28E with the college student aid commission for
2 the administration of the center's grant and loan repayment
3 programs.

4 a. Community Health care workforce and community support
5 grant program.

6 (1) The center for rural health and primary care shall adopt
7 rules establishing an flexible application process processes
8 based upon the department's strategic plan to be used by the
9 center to establish a grant assistance program as provided
10 in this paragraph "a", and establishing the criteria to be
11 used in evaluating the applications. Selection criteria
12 shall include a method for prioritizing grant applications
13 based on illustrated efforts to meet the health care provider
14 needs of the locality and surrounding area. Such assistance
15 may be in the form of a forgivable loan, grant, or other
16 nonfinancial assistance as deemed appropriate by the center.
17 An application submitted ~~shall~~ may contain a commitment of ~~at~~
18 ~~least a dollar-for-dollar match of~~ matching funds for the grant
19 assistance. Application may be made for assistance by a single
20 community or group of communities or in response to programs
21 recommended in the strategic plan to address health workforce
22 shortages.

23 (2) Grants awarded under the program shall be ~~subject to the~~
24 ~~following limitations:~~

25 ~~(a) Ten thousand dollars for a single community or region~~
26 ~~with a population of ten thousand or less. An award shall not~~
27 ~~be made under this program to a community with a population of~~
28 ~~more than ten thousand.~~

29 ~~(b) An amount not to exceed one dollar per capita for a~~
30 ~~region in which the population exceeds ten thousand. For~~
31 ~~purposes of determining the amount of a grant for a region,~~
32 ~~the population of the region shall not include the population~~
33 ~~of any community with a population of more than ten thousand~~
34 ~~located in the region~~ awarded to rural, underserved areas or
35 special populations as identified by the department's strategic

1 plan or evidence-based documentation.

2 *b. Primary care provider loan repayment program.*

3 (1) A primary care provider loan repayment program is
4 established to increase the number of health professionals
5 practicing primary care in federally designated health
6 professional shortage areas of the state. Under the program,
7 loan repayment may be made to a recipient for educational
8 expenses incurred while completing an accredited health
9 education program directly related to obtaining credentials
10 necessary to practice the recipient's health profession.

11 (2) The center for rural health and primary care shall adopt
12 rules relating to the establishment and administration of the
13 primary care provider loan repayment program. Rules adopted
14 pursuant to this paragraph shall provide, at a minimum, for all
15 of the following:

16 (a) Determination of eligibility requirements and
17 qualifications of an applicant to receive loan repayment under
18 the program, including but not limited to years of obligated
19 service, clinical practice requirements, and residency
20 requirements. One year of obligated service shall be provided
21 by the applicant in exchange for each year of loan repayment,
22 unless federal requirements otherwise require. Loan repayment
23 under the program shall not be approved for a health provider
24 whose license or certification is restricted by a medical
25 regulatory authority of any jurisdiction of the United States,
26 other nations, or territories.

27 (b) Identification of federally designated health
28 professional shortage areas of the state and prioritization of
29 such areas according to need.

30 (c) Determination of the amount and duration of the loan
31 repayment an applicant may receive, giving consideration to the
32 availability of funds under the program, and the applicant's
33 outstanding educational loans and professional credentials.

34 (d) Determination of the conditions of loan repayment
35 applicable to an applicant.

1 (e) Enforcement of the state's rights under a loan repayment
2 program contract, including the commencement of any court
3 action.

4 (f) Cancellation of a loan repayment program contract for
5 reasonable cause unless federal requirements otherwise require.

6 (g) Participation in federal programs supporting repayment
7 of loans of health care providers and acceptance of gifts,
8 grants, and other aid or amounts from any person, association,
9 foundation, trust, corporation, governmental agency, or other
10 entity for the purposes of the program.

11 (h) Upon availability of state funds, determination of
12 eligibility criteria and qualifications for participating
13 communities and applicants not located in federally designated
14 shortage areas.

15 (i) Other rules as necessary.

16 ~~{3} The center for rural health and primary care may enter~~
17 ~~into an agreement under chapter 28E with the college student~~
18 ~~aid commission for the administration of this program.~~

19 ~~*e. Primary care provider community scholarship program.*~~

20 ~~{1} A primary care provider community scholarship program~~
21 ~~is established to recruit and to provide scholarships to train~~
22 ~~primary health care practitioners in federally designated~~
23 ~~health professional shortage areas of the state. Under~~
24 ~~the program, scholarships may be awarded to a recipient for~~
25 ~~educational expenses incurred while completing an accredited~~
26 ~~health education program directly related to obtaining the~~
27 ~~credentials necessary to practice the recipient's health~~
28 ~~profession.~~

29 ~~{2} The department shall adopt rules relating to the~~
30 ~~establishment and administration of the primary care provider~~
31 ~~community scholarship program. Rules adopted pursuant to~~
32 ~~this paragraph shall provide, at a minimum, for all of the~~
33 ~~following:~~

34 ~~{a} Determination of eligibility requirements and~~
35 ~~qualifications of an applicant to receive scholarships under~~

1 ~~the program, including but not limited to years of obligated~~
2 ~~service, clinical practice requirements, and residency~~
3 ~~requirements. One year of obligated service shall be provided~~
4 ~~by the applicant in exchange for each year of scholarship~~
5 ~~receipt, unless federal requirements otherwise require.~~

6 ~~(b) Identification of federally designated health~~
7 ~~professional shortage areas of the state and prioritization of~~
8 ~~such areas according to need.~~

9 ~~(c) Determination of the amount of the scholarship an~~
10 ~~applicant may receive.~~

11 ~~(d) Determination of the conditions of scholarship to be~~
12 ~~awarded to an applicant.~~

13 ~~(e) Enforcement of the state's rights under a scholarship~~
14 ~~contract, including the commencement of any court action.~~

15 ~~(f) Cancellation of a scholarship contract for reasonable~~
16 ~~cause.~~

17 ~~(g) Participation in federal programs supporting~~
18 ~~scholarships for health care providers and acceptance of gifts,~~
19 ~~grants, and other aid or amounts from any person, association,~~
20 ~~foundation, trust, corporation, governmental agency, or other~~
21 ~~entity for the purposes of the program.~~

22 ~~(h) Upon availability of state funds, determination of~~
23 ~~eligibility criteria and qualifications for participating~~
24 ~~communities and applicants not located in federally designated~~
25 ~~shortage areas.~~

26 ~~(i) Other rules as necessary.~~

27 ~~(3) The center for rural health and primary care may enter~~
28 ~~into an agreement under [chapter 28E](#) with the college student~~
29 ~~aid commission for the administration of this program.~~

30 Sec. 13. Section 135.107, subsection 4, paragraphs a, b, and
31 c, Code 2017, are amended to read as follows:

32 a. Eligibility under any of the programs established under
33 the primary care provider recruitment and retention endeavor
34 shall be based upon a community health services assessment
35 completed under [subsection 2](#), paragraph "a". A community

1 ~~or region, as applicable, shall submit a letter of intent~~
 2 ~~to conduct a community health services assessment and to~~
 3 ~~apply for assistance under this subsection. The letter shall~~
 4 ~~be in a form and contain information as determined by the~~
 5 ~~center. A letter of intent shall be submitted to the center by~~
 6 ~~January 1 preceding the fiscal year for which an application~~
 7 ~~for assistance is to be made. Participation in a community~~
 8 ~~health services assessment process shall be documented by the~~
 9 ~~community or region.~~

10 b. Assistance under this subsection shall not be granted
 11 until such time as the community or region making application
 12 has completed ~~the~~ a community health services assessment and
 13 adopted a long-term community health services assessment and
 14 developmental plan. In addition to any other requirements, a
 15 ~~developmental~~ an applicant's plan shall include, to the extent
 16 possible, a clear commitment to informing high school students
 17 of the health care opportunities which may be available to such
 18 students.

19 c. The center for rural health and primary care shall
 20 seek additional assistance and resources from other state
 21 departments and agencies, federal agencies and grant programs,
 22 private organizations, and any other person, as appropriate.
 23 The center is authorized and directed to accept on behalf of
 24 the state any grant or contribution, federal or otherwise,
 25 made to assist in meeting the cost of carrying out the purpose
 26 of this subsection. All federal grants to and the federal
 27 receipts of the center are appropriated for the purpose set
 28 forth in such federal grants or receipts. Funds appropriated
 29 by the general assembly to the center for implementation of
 30 this subsection shall first be used for securing any available
 31 federal funds requiring a state match, with remaining funds
 32 being used for the health care workforce and community support
 33 grant program.

34 Sec. 14. Section 135.107, subsection 5, paragraph a, Code
 35 2017, is amended to read as follows:

1 a. There is established an advisory committee to the
2 center for rural health and primary care consisting of one
3 representative, approved by the respective agency, of each
4 of the following agencies: the department of agriculture
5 and land stewardship, the Iowa department of public health,
6 the department of inspections and appeals, the a national or
7 regional institute for rural health policy, ~~the rural health~~
8 ~~resource center~~, the institute of agricultural medicine
9 and occupational health, and the Iowa state association of
10 counties. The governor shall appoint two representatives
11 of consumer groups active in rural health issues and a
12 representative of each of two farm organizations active within
13 the state, a representative of an agricultural business in
14 the state, a representative of a critical needs hospital,
15 a practicing rural family physician, a practicing rural
16 physician assistant, a practicing rural advanced registered
17 nurse practitioner, and a rural health practitioner who is
18 not a physician, physician assistant, or advanced registered
19 nurse practitioner, as members of the advisory committee. The
20 advisory committee shall also include as members two state
21 representatives, one appointed by the speaker of the house of
22 representatives and one by the minority leader of the house,
23 and two state senators, one appointed by the majority leader of
24 the senate and one by the minority leader of the senate.

25 Sec. 15. Section 135.163, Code 2017, is amended to read as
26 follows:

27 **135.163 Health and ~~long-term~~ care access.**

28 The department shall coordinate public and private efforts
29 to develop and maintain an appropriate health care delivery
30 infrastructure and a stable, well-qualified, diverse, and
31 sustainable health care workforce in this state. The health
32 care delivery infrastructure and the health care workforce
33 shall address the broad spectrum of health care needs of Iowans
34 throughout their lifespan ~~including long-term care needs~~. The
35 department shall, at a minimum, do all of the following:

1 1. Develop a strategic plan for health care delivery
2 infrastructure and health care workforce resources in this
3 state.

4 2. Provide for the continuous collection of data to provide
5 a basis for health care strategic planning and health care
6 policymaking.

7 3. Make recommendations regarding the health care delivery
8 infrastructure and the health care workforce that assist
9 in monitoring current needs, predicting future trends, and
10 informing policymaking.

11 Sec. 16. Section 135.175, subsection 1, paragraph b, Code
12 2017, is amended to read as follows:

13 b. A health care workforce shortage fund is created in
14 the state treasury as a separate fund under the control of
15 the department, in cooperation with the entities identified
16 in [this section](#) as having control over the accounts within
17 the fund. The fund and the accounts within the fund shall
18 be controlled and managed in a manner consistent with the
19 principles specified and the strategic plan developed pursuant
20 to ~~sections~~ [section 135.163](#) and ~~135.164~~.

21 Sec. 17. Section 135.175, subsections 6 and 7, Code 2017,
22 are amended to read as follows:

23 6. a. Moneys in the fund and the accounts in the fund shall
24 only be appropriated in a manner consistent with the principles
25 specified and the strategic plan developed pursuant to ~~sections~~
26 [section 135.163](#) and ~~135.164~~ to support the medical residency
27 training state matching grants program, the fulfilling Iowa's
28 need for dentists matching grant program, and to provide
29 funding for state health care workforce shortage programs as
30 provided in [this section](#).

31 b. State programs that may receive funding from the fund
32 and the accounts in the fund, if specifically designated for
33 the purpose of drawing down federal funding, are the primary
34 care recruitment and retention endeavor (PRIMECARRE), the Iowa
35 affiliate of the national rural recruitment and retention

1 network, the oral and health delivery systems bureau of the
2 department, the primary care office and shortage designation
3 program, and the state office of rural health, ~~and the Iowa~~
4 ~~health workforce center~~, administered through the oral and
5 health delivery systems bureau of health care access of the
6 department of public health; ~~the area health education centers~~
7 ~~programs at Des Moines university — osteopathic medical center~~
8 ~~and the university of Iowa; the Iowa collaborative safety net~~
9 ~~provider network established pursuant to section 135.153~~; any
10 entity identified by the federal government entity through
11 which federal funding for a specified health care workforce
12 shortage initiative is received; and a program developed in
13 accordance with the strategic plan developed by the department
14 of public health in accordance with ~~sections~~ section 135.163
15 ~~and 135.164~~.

16 *c.* ~~State appropriations to the fund shall be allocated in~~
17 ~~equal amounts to each of the accounts within the fund, unless~~
18 ~~otherwise specified in the appropriation or allocation. Any~~
19 federal funding received for the purposes of addressing state
20 health care workforce shortages shall be deposited in the
21 health care workforce shortage national initiatives account,
22 unless otherwise specified by the source of the funds, and
23 shall be used as required by the source of the funds. If use
24 of the federal funding is not designated, the funds shall be
25 used in accordance with the strategic plan developed by the
26 department of public health in accordance with ~~sections~~ section
27 135.163 and 135.164, or to address workforce shortages as
28 otherwise designated by the department of public health. Other
29 sources of funding shall be deposited in the fund or account
30 and used as specified by the source of the funding.

31 7. No more than five percent of the moneys in any of the
32 accounts within the fund, ~~not to exceed one hundred thousand~~
33 ~~dollars in each account~~, shall be used for administrative
34 purposes, unless otherwise provided by the appropriation,
35 allocation, or source of the funds.

1 Sec. 18. REPEAL. Sections 135.164 and 135.180, Code 2017,
2 are repealed.

3 DIVISION IV

4 UNFUNDED OR OUTDATED PROGRAM PROVISIONS

5 Sec. 19. Section 135.11, subsection 25, Code 2017, is
6 amended by striking the subsection.

7 Sec. 20. Section 135.141, subsection 2, paragraph c, Code
8 2017, is amended by striking the paragraph.

9 Sec. 21. Section 135.141, subsection 2, paragraph e, Code
10 2017, is amended to read as follows:

11 e. For the purpose of ~~paragraphs "c" and~~ paragraph "d",
12 an employee or agent of the department may enter into and
13 examine any premises containing potentially dangerous agents
14 with the consent of the owner or person in charge of the
15 premises or, if the owner or person in charge of the premises
16 refuses admittance, with an administrative search warrant
17 obtained under section 808.14. Based on findings of the risk
18 assessment and examination of the premises, the director may
19 order reasonable safeguards or take any other action reasonably
20 necessary to protect the public health pursuant to rules
21 adopted to administer this subsection.

22 Sec. 22. Section 901B.1, subsection 4, paragraph a, Code
23 2017, is amended to read as follows:

24 a. The district department of correctional services shall
25 place an individual committed to it under section 907.3 to the
26 sanction and level of supervision which is appropriate to the
27 individual based upon a current risk assessment evaluation.
28 Placements may be to levels two and three of the corrections
29 continuum. ~~The district department may, with the approval of~~
30 ~~the Iowa department of public health and the department of~~
31 ~~corrections, place an individual in a level three substance~~
32 ~~abuse treatment facility established pursuant to section~~
33 ~~135.130, to assist the individual in complying with a condition~~
34 ~~of probation.~~ The district department may, with the approval
35 of the department of corrections, place an individual in a

1 level four violator facility established pursuant to section
2 904.207 only as a penalty for a violation of a condition
3 imposed under [this section](#).

4 Sec. 23. REPEAL. Sections 135.26, 135.29, 135.130, and
5 135.152, Code 2017, are repealed.

6 DIVISION V

7 MISCELLANEOUS PROVISIONS

8 Sec. 24. Section 135A.2, subsection 6, Code 2017, is amended
9 to read as follows:

10 6. "*Local board of health*" means ~~a county or district board~~
11 ~~of health~~ the same as defined in section 137.102.

12 Sec. 25. REPEAL. Section 135.132, Code 2017, is repealed.

13 DIVISION VI

14 IOWA HEALTH INFORMATION NETWORK

15 Sec. 26. Section 136.3, subsection 13, Code 2017, is amended
16 to read as follows:

17 13. Perform those duties authorized pursuant to ~~sections~~
18 ~~135.156 and~~ section 135.159 and other provisions of law.

19 Sec. 27. EFFECTIVE DATE. This division of this Act
20 takes effect upon the assumption of the administration and
21 governance, including but not limited to the assumption of the
22 assets and liabilities, of the Iowa health information network
23 by the designated entity as defined in 2015 Iowa Acts, ch.73,
24 section 2. The department of public health shall notify the
25 Code editor of the date of such assumption by the designated
26 entity.

27 DIVISION VII

28 ORGANIZED DELIVERY SYSTEMS

29 Sec. 28. Section 135H.3, subsection 2, Code 2017, is amended
30 to read as follows:

31 2. If a child is diagnosed with a biologically based mental
32 illness as defined in [section 514C.22](#) and meets the medical
33 assistance program criteria for admission to a psychiatric
34 medical institution for children, the child shall be deemed
35 to meet the acuity criteria for medically necessary inpatient

1 benefits under a group policy, contract, or plan providing
2 for third-party payment or prepayment of health, medical, and
3 surgical coverage benefits issued by a carrier, as defined in
4 section 513B.2, ~~or by an organized delivery system authorized~~
5 ~~under 1993 Iowa Acts, ch. 158,~~ that is subject to section
6 514C.22. Such medically necessary benefits shall not be
7 excluded or denied as care that is substantially custodial in
8 nature under [section 514C.22, subsection 8](#), paragraph "b".

9 Sec. 29. Section 505.32, subsection 2, paragraph h, Code
10 2017, is amended by striking the paragraph.

11 Sec. 30. Section 505.32, subsection 4, paragraph b,
12 subparagraphs (1) and (2), Code 2017, are amended to read as
13 follows:

14 (1) The commissioner may establish methodologies to provide
15 uniform and consistent side-by-side comparisons of the health
16 care coverage options that are offered by carriers, ~~organized~~
17 ~~delivery systems,~~ and public programs in this state including
18 but not limited to benefits covered and not covered, the amount
19 of coverage for each service, including copays and deductibles,
20 administrative costs, and any prior authorization requirements
21 for coverage.

22 (2) The commissioner may require each carrier, ~~organized~~
23 ~~delivery system,~~ and public program in this state to describe
24 each health care coverage option offered by that carrier,
25 ~~organized delivery system,~~ or public program in a manner
26 so that the various options can be compared as provided in
27 subparagraph (1).

28 Sec. 31. Section 507B.4, subsection 1, Code 2017, is amended
29 to read as follows:

30 1. For purposes of [subsection 3](#), paragraph "p", "insurer"
31 means an entity providing a plan of health insurance, health
32 care benefits, or health care services, or an entity subject
33 to the jurisdiction of the commissioner performing utilization
34 review, including an insurance company offering sickness and
35 accident plans, a health maintenance organization, ~~an organized~~

1 ~~delivery system authorized under 1993 Iowa Acts, ch. 158, and~~
 2 ~~licensed by the department of public health,~~ a nonprofit health
 3 service corporation, a plan established pursuant to chapter
 4 509A for public employees, or any other entity providing a
 5 plan of health insurance, health care benefits, or health care
 6 services. However, "insurer" does not include an entity that
 7 sells disability income or long-term care insurance.

8 Sec. 32. Section 507B.4A, subsection 2, paragraph a, Code
 9 2017, is amended to read as follows:

10 a. An insurer providing accident and sickness insurance
 11 under [chapter 509, 514, or 514A](#); a health maintenance
 12 organization; ~~an organized delivery system authorized under~~
 13 ~~1993 Iowa Acts, ch. 158, and licensed by the department of~~
 14 ~~public health;~~ or another entity providing health insurance or
 15 health benefits subject to state insurance regulation shall
 16 either accept and pay or deny a clean claim.

17 Sec. 33. Section 509.3A, subsection 11, Code 2017, is
 18 amended by striking the subsection.

19 Sec. 34. Section 509.19, subsection 2, paragraph d, Code
 20 2017, is amended by striking the paragraph.

21 Sec. 35. Section 509A.6, Code 2017, is amended to read as
 22 follows:

23 **509A.6 Contract with insurance carrier, or health maintenance**
 24 **organization, ~~or organized delivery system.~~**

25 The governing body may contract with a nonprofit corporation
 26 operating under the provisions of [this chapter](#) or chapter
 27 514 or with any insurance company having a certificate of
 28 authority to transact an insurance business in this state with
 29 respect of a group insurance plan, which may include life,
 30 accident, health, hospitalization and disability insurance
 31 during period of active service of such employees, with the
 32 right of any employee to continue such life insurance in force
 33 after termination of active service at such employee's sole
 34 expense; may contract with a nonprofit corporation operating
 35 under and governed by the provisions of [this chapter](#) or chapter

1 514 with respect of any hospital or medical service plan; and
2 may contract with a health maintenance organization ~~or an~~
3 ~~organized delivery system~~ authorized to operate in this state
4 with respect to health maintenance organization ~~or organized~~
5 ~~delivery system~~ activities.

6 Sec. 36. Section 513B.2, subsection 8, paragraph k, Code
7 2017, is amended by striking the paragraph.

8 Sec. 37. Section 513B.5, Code 2017, is amended to read as
9 follows:

10 **513B.5 Provisions on renewability of coverage.**

11 1. Health insurance coverage subject to **this chapter** is
12 renewable with respect to all eligible employees or their
13 dependents, at the option of the small employer, except for one
14 or more of the following reasons:

15 a. The health insurance coverage sponsor fails to pay, or to
16 make timely payment of, premiums or contributions pursuant to
17 the terms of the health insurance coverage.

18 b. The health insurance coverage sponsor performs an
19 act or practice constituting fraud or makes an intentional
20 misrepresentation of a material fact under the terms of the
21 coverage.

22 c. Noncompliance with the carrier's ~~or organized delivery~~
23 ~~system's~~ minimum participation requirements.

24 d. Noncompliance with the carrier's ~~or organized delivery~~
25 ~~system's~~ employer contribution requirements.

26 e. A decision by the carrier ~~or organized delivery system~~
27 to discontinue offering a particular type of health insurance
28 coverage in the state's small employer market. Health
29 insurance coverage may be discontinued by the carrier ~~or~~
30 ~~organized delivery system~~ in that market only if the carrier ~~or~~
31 ~~organized delivery system~~ does all of the following:

32 (1) Provides advance notice of its decision to discontinue
33 such plan to the commissioner ~~or director of public health~~.
34 Notice to the commissioner ~~or director~~, at a minimum, shall be
35 no less than three days prior to the notice provided for in

1 subparagraph (2) to affected small employers, participants, and
2 beneficiaries.

3 (2) Provides notice of its decision not to renew such
4 plan to all affected small employers, participants, and
5 beneficiaries no less than ninety days prior to the nonrenewal
6 of the plan.

7 (3) Offers to each plan sponsor of the discontinued
8 coverage, the option to purchase any other coverage currently
9 offered by the carrier ~~or organized delivery system~~ to other
10 employers in this state.

11 (4) Acts uniformly, in opting to discontinue the coverage
12 and in offering the option under subparagraph (3), without
13 regard to the claims experience of the sponsors under the
14 discontinued coverage or to a health status-related factor
15 relating to any participants or beneficiaries covered or new
16 participants or beneficiaries who may become eligible for the
17 coverage.

18 *f.* A decision by the carrier ~~or organized delivery system~~ to
19 discontinue offering and to cease to renew all of its health
20 insurance coverage delivered or issued for delivery to small
21 employers in this state. A carrier ~~or organized delivery~~
22 ~~system~~ making such decision shall do all of the following:

23 (1) Provide advance notice of its decision to discontinue
24 such coverage to the commissioner ~~or director of public health~~.
25 Notice to the commissioner ~~or director~~, at a minimum, shall be
26 no less than three days prior to the notice provided for in
27 subparagraph (2) to affected small employers, participants, and
28 beneficiaries.

29 (2) Provide notice of its decision not to renew such
30 coverage to all affected small employers, participants, and
31 beneficiaries no less than one hundred eighty days prior to the
32 nonrenewal of the coverage.

33 (3) Discontinue all health insurance coverage issued or
34 delivered for issuance to small employers in this state and
35 cease renewal of such coverage.

1 *g.* The membership of an employer in an association, which
2 is the basis for the coverage which is provided through such
3 association, ceases, but only if the termination of coverage
4 under this paragraph occurs uniformly without regard to
5 any health status-related factor relating to any covered
6 individual.

7 *h.* The commissioner ~~or director of public health~~ finds that
8 the continuation of the coverage is not in the best interests
9 of the policyholders or certificate holders, or would impair
10 the carrier's ~~or organized delivery system's~~ ability to meet
11 its contractual obligations.

12 *i.* At the time of coverage renewal, a carrier ~~or organized~~
13 ~~delivery system~~ may modify the health insurance coverage for
14 a product offered under group health insurance coverage in
15 the small group market, for coverage that is available in
16 such market other than only through one or more bona fide
17 associations, if such modification is consistent with the laws
18 of this state, and is effective on a uniform basis among group
19 health insurance coverage with that product.

20 2. A carrier ~~or organized delivery system~~ that elects not to
21 renew health insurance coverage under [subsection 1](#), paragraph
22 "f", shall not write any new business in the small employer
23 market in this state for a period of five years after the date
24 of notice to the commissioner ~~or director of public health~~.

25 3. [This section](#), with respect to a carrier ~~or organized~~
26 ~~delivery system~~ doing business in one established geographic
27 service area of the state, applies only to such carrier's ~~or~~
28 ~~organized delivery system's~~ operations in that service area.

29 Sec. 38. Section 513B.6, unnumbered paragraph 1, Code 2017,
30 is amended to read as follows:

31 A small employer carrier ~~or organized delivery system~~ shall
32 make reasonable disclosure in solicitation and sales materials
33 provided to small employers of all of the following:

34 Sec. 39. Section 513B.6, subsection 2, Code 2017, is amended
35 to read as follows:

1 2. The provisions concerning the small employer carrier's
2 ~~or organized delivery system's~~ right to change premium rates
3 and factors, including case characteristics, which affect
4 changes in premium rates.

5 Sec. 40. Section 513B.7, Code 2017, is amended to read as
6 follows:

7 **513B.7 Maintenance of records.**

8 1. A small employer carrier ~~or organized delivery system~~
9 shall maintain at its principal place of business a complete
10 and detailed description of its rating practices and renewal
11 underwriting practices, including information and documentation
12 which demonstrate that its rating methods and practices are
13 based upon commonly accepted actuarial assumptions and are in
14 accordance with sound actuarial principles.

15 2. A small employer carrier ~~or organized delivery system~~
16 shall file each March 1 with the commissioner ~~or the director~~
17 ~~of public health~~ an actuarial certification that the small
18 employer carrier ~~or organized delivery system~~ is in compliance
19 with [this section](#) and that the rating methods of the small
20 employer carrier ~~or organized delivery system~~ are actuarially
21 sound. A copy of the certification shall be retained by the
22 small employer carrier ~~or organized delivery system~~ at its
23 principal place of business.

24 3. A small employer carrier ~~or organized delivery system~~
25 shall make the information and documentation described in
26 subsection 1 available to the commissioner ~~or the director of~~
27 ~~public health~~ upon request. The information is not a public
28 record or otherwise subject to disclosure under [chapter 22](#),
29 and is considered proprietary and trade secret information
30 and is not subject to disclosure by the commissioner ~~or the~~
31 ~~director of public health~~ to persons outside of the division ~~or~~
32 ~~department~~ except as agreed to by the small employer carrier ~~or~~
33 ~~organized delivery system~~ or as ordered by a court of competent
34 jurisdiction.

35 Sec. 41. Section 513B.9A, subsection 1, unnumbered

1 paragraph 1, Code 2017, is amended to read as follows:

2 A carrier ~~or organized delivery system~~ offering group health
3 insurance coverage shall not establish rules for eligibility,
4 including continued eligibility, of an individual to enroll
5 under the terms of the coverage based on any of the following
6 health status-related factors in relation to the individual or
7 a dependent of the individual:

8 Sec. 42. Section 513B.9A, subsection 4, paragraph a, Code
9 2017, is amended to read as follows:

10 a. A carrier ~~or organized delivery system~~ offering health
11 insurance coverage shall not require an individual, as a
12 condition of enrollment or continued enrollment under the
13 coverage, to pay a premium or contribution which is greater
14 than a premium or contribution for a similarly situated
15 individual enrolled in the coverage on the basis of a health
16 status-related factor in relation to the individual or to a
17 dependent of an individual enrolled under the coverage.

18 Sec. 43. Section 513B.9A, subsection 4, paragraph b,
19 subparagraph (2), Code 2017, is amended to read as follows:

20 (2) Prevent a carrier ~~or organized delivery system~~
21 offering group health insurance coverage from establishing
22 premium discounts or rebates or modifying otherwise applicable
23 copayments or deductibles in return for adherence to programs
24 of health promotion and disease prevention.

25 Sec. 44. Section 513B.10, Code 2017, is amended to read as
26 follows:

27 **513B.10 Availability of coverage.**

28 1. a. A carrier ~~or an organized delivery system~~ that offers
29 health insurance coverage in the small group market shall
30 accept every small employer that applies for health insurance
31 coverage and shall accept for enrollment under such coverage
32 every eligible individual who applies for enrollment during the
33 period in which the individual first becomes eligible to enroll
34 under the terms of the health insurance coverage and shall not
35 place any restriction which is inconsistent with eligibility

1 rules established under **this chapter**.

2 *b.* A carrier ~~or organized delivery system~~ that offers health
3 insurance coverage in the small group market through a network
4 plan may do either of the following:

5 (1) Limit employers that may apply for such coverage to
6 those with eligible individuals who live, work, or reside in
7 the service area for such network plan.

8 (2) Deny such coverage to such employers within the service
9 area of such plan if the carrier ~~or organized delivery system~~
10 has demonstrated to the applicable state authority both of the
11 following:

12 (a) The carrier ~~or organized delivery system~~ will not have
13 the capacity to deliver services adequately to enrollees of any
14 additional groups because of its obligations to existing group
15 contract holders and enrollees.

16 (b) The carrier ~~or organized delivery system~~ is applying
17 this subparagraph uniformly to all employers without regard to
18 the claims experience of those employers and their employees
19 and their dependents, or any health status-related factor
20 relating to such employees or dependents.

21 *c.* A carrier ~~or organized delivery system~~, upon denying
22 health insurance coverage in any service area pursuant to
23 paragraph "b", subparagraph (2), shall not offer coverage in the
24 small group market within such service area for a period of one
25 hundred eighty days after the date such coverage is denied.

26 *d.* A carrier ~~or organized delivery system~~ may deny health
27 insurance coverage in the small group market if the issuer has
28 demonstrated to the commissioner ~~or director of public health~~
29 both of the following:

30 (1) The carrier ~~or organized delivery system~~ does not have
31 the financial reserves necessary to underwrite additional
32 coverage.

33 (2) The carrier ~~or organized delivery system~~ is applying the
34 provisions of this paragraph uniformly to all employers in the
35 small group market in this state consistent with state law and

1 without regard to the claims experience of those employers and
2 the employees and dependents of such employers, or any health
3 status-related factor relating to such employees and their
4 dependents.

5 *e.* A carrier ~~or organized delivery system~~, upon denying
6 health insurance coverage pursuant to paragraph "d", shall not
7 offer coverage in connection with health insurance coverages
8 in the small group market in this state for a period of one
9 hundred eighty days after the date such coverage is denied or
10 until the carrier ~~or organized delivery system~~ has demonstrated
11 to the commissioner ~~or director of public health~~ that the
12 carrier ~~or organized delivery system~~ has sufficient financial
13 reserves to underwrite additional coverage, whichever is later.
14 The commissioner ~~or director~~ may provide for the application of
15 this paragraph on a service area-specific basis.

16 *f.* Paragraph "a" shall not be construed to preclude
17 a carrier ~~or organized delivery system~~ from establishing
18 employer contribution rules or group participation rules for
19 the offering of health insurance coverage in the small group
20 market.

21 2. A carrier ~~or organized delivery system~~, subject to
22 subsection 1, shall issue health insurance coverage to an
23 eligible small employer that applies for the coverage and
24 agrees to make the required premium payments and satisfy the
25 other reasonable provisions of the health insurance coverage
26 not inconsistent with [this chapter](#). A carrier ~~or organized~~
27 ~~delivery system~~ is not required to issue health insurance
28 coverage to a self-employed individual who is covered by, or is
29 eligible for coverage under, health insurance coverage offered
30 by an employer.

31 3. Health insurance coverage for small employers shall
32 satisfy all of the following:

33 *a.* A carrier ~~or organized delivery system~~ offering group
34 health insurance coverage, with respect to a participant or
35 beneficiary, may impose a preexisting condition exclusion only

1 as follows:

2 (1) The exclusion relates to a condition, whether physical
3 or mental, regardless of the cause of the condition, for
4 which medical advice, diagnosis, care, or treatment was
5 recommended or received within the six-month period ending on
6 the enrollment date. However, genetic information shall not be
7 treated as a condition under this subparagraph in the absence
8 of a diagnosis of the condition related to such information.

9 (2) The exclusion extends for a period of not more than
10 twelve months, or eighteen months in the case of a late
11 enrollee, after the enrollment date.

12 (3) The period of any such preexisting condition exclusion
13 is reduced by the aggregate of the periods of creditable
14 coverage applicable to the participant or beneficiary as of the
15 enrollment date.

16 *b.* A carrier ~~or organized delivery system~~ offering group
17 health insurance coverage shall not impose any preexisting
18 condition exclusion as follows:

19 (1) In the case of a child who is adopted or placed for
20 adoption before attaining eighteen years of age and who, as of
21 the last day of the thirty-day period beginning on the date
22 of the adoption or placement for adoption, is covered under
23 creditable coverage. This subparagraph shall not apply to
24 coverage before the date of such adoption or placement for
25 adoption.

26 (2) In the case of an individual who, as of the last day
27 of the thirty-day period beginning with the date of birth, is
28 covered under creditable coverage.

29 (3) Relating to pregnancy as a preexisting condition.

30 *c.* A carrier ~~or organized delivery system~~ shall waive
31 any waiting period applicable to a preexisting condition
32 exclusion or limitation period with respect to particular
33 services under health insurance coverage for the period
34 of time an individual was covered by creditable coverage,
35 provided that the creditable coverage was continuous to a

1 date not more than sixty-three days prior to the effective
2 date of the new coverage. Any period that an individual
3 is in a waiting period for any coverage under group health
4 insurance coverage, or is in an affiliation period, shall not
5 be taken into account in determining the period of continuous
6 coverage. A health maintenance organization that does not
7 use preexisting condition limitations in any of its health
8 insurance coverage may impose an affiliation period. For
9 purposes of [this section](#), "*affiliation period*" means a period
10 of time not to exceed sixty days for new entrants and not to
11 exceed ninety days for late enrollees during which no premium
12 shall be collected and coverage issued is not effective, so
13 long as the affiliation period is applied uniformly, without
14 regard to any health status-related factors. This paragraph
15 does not preclude application of a waiting period applicable
16 to all new enrollees under the health insurance coverage,
17 provided that any ~~carrier or organized delivery system-imposed~~
18 carrier-imposed waiting period is no longer than sixty days and
19 is used in lieu of a preexisting condition exclusion.

20 d. Health insurance coverage may exclude coverage for late
21 enrollees for preexisting conditions for a period not to exceed
22 eighteen months.

23 e. (1) Requirements used by a carrier ~~or organized delivery~~
24 ~~system~~ in determining whether to provide coverage to a small
25 employer shall be applied uniformly among all small employers
26 applying for coverage or receiving coverage from the carrier
27 ~~or organized delivery system~~.

28 (2) In applying minimum participation requirements with
29 respect to a small employer, a carrier ~~or organized delivery~~
30 ~~system~~ shall not consider employees or dependents who have
31 other creditable coverage in determining whether the applicable
32 percentage of participation is met.

33 (3) A carrier ~~or organized delivery system~~ shall not
34 increase any requirement for minimum employee participation
35 or modify any requirement for minimum employer contribution

1 applicable to a small employer at any time after the small
2 employer has been accepted for coverage.

3 *f.* (1) If a carrier ~~or organized delivery system~~ offers
4 coverage to a small employer, the carrier ~~or organized delivery~~
5 ~~system~~ shall offer coverage to all eligible employees of the
6 small employer and the employees' dependents. A carrier ~~or~~
7 ~~organized delivery system~~ shall not offer coverage to only
8 certain individuals or dependents in a small employer group or
9 to only part of the group.

10 (2) Except as provided under paragraphs "a" and "d", a
11 carrier ~~or organized delivery system~~ shall not modify health
12 insurance coverage with respect to a small employer or any
13 eligible employee or dependent through riders, endorsements, or
14 other means, to restrict or exclude coverage or benefits for
15 certain diseases, medical conditions, or services otherwise
16 covered by the health insurance coverage.

17 *g.* A carrier ~~or organized delivery system~~ offering coverage
18 through a network plan shall not be required to offer coverage
19 or accept applications pursuant to [subsection 1](#) with respect to
20 a small employer where any of the following ~~apply~~ applies:

21 (1) The small employer does not have eligible individuals
22 who live, work, or reside in the service area for the network
23 plan.

24 (2) The small employer does have eligible individuals who
25 live, work, or reside in the service area for the network plan,
26 but the carrier ~~or organized delivery system~~, if required, has
27 demonstrated to the commissioner ~~or the director of public~~
28 ~~health~~ that it will not have the capacity to deliver services
29 adequately to enrollees of any additional groups because of its
30 obligations to existing group contract holders and enrollees
31 and that it is applying the requirements of this lettered
32 paragraph uniformly to all employers without regard to the
33 claims experience of those employers and their employees and
34 the employees' dependents, or any health status-related factor
35 relating to such employees and dependents.

1 (3) A carrier ~~or organized delivery system~~, upon denying
2 health insurance coverage in a service area pursuant to
3 subparagraph (2), shall not offer coverage in the small
4 employer market within such service area for a period of one
5 hundred eighty days after the coverage is denied.

6 4. A carrier ~~or organized delivery system~~ shall not be
7 required to offer coverage to small employers pursuant to
8 subsection 1 for any period of time where the commissioner ~~or~~
9 ~~director of public health~~ determines that the acceptance of the
10 offers by small employers in accordance with [subsection 1](#) would
11 place the carrier ~~or organized delivery system~~ in a financially
12 impaired condition.

13 5. A carrier ~~or organized delivery system~~ shall not be
14 required to provide coverage to small employers pursuant to
15 subsection 1 if the carrier ~~or organized delivery system~~ elects
16 not to offer new coverage to small employers in this state.
17 However, a carrier ~~or organized delivery system~~ that elects not
18 to offer new coverage to small employers under [this subsection](#)
19 shall be allowed to maintain its existing policies in the
20 state, subject to the requirements of [section 513B.5](#).

21 6. A carrier ~~or organized delivery system~~ that elects not to
22 offer new coverage to small employers pursuant to [subsection 5](#)
23 shall provide notice to the commissioner ~~or director of public~~
24 ~~health~~ and is prohibited from writing new business in the small
25 employer market in this state for a period of five years from
26 the date of notice to the commissioner ~~or director~~.

27 Sec. 45. Section 513C.3, subsection 5, Code 2017, is amended
28 to read as follows:

29 5. "*Carrier*" means any entity that provides individual
30 health benefit plans in this state. For purposes of this
31 chapter, carrier includes an insurance company, a group
32 hospital or medical service corporation, a fraternal benefit
33 society, a health maintenance organization, and any other
34 entity providing an individual plan of health insurance
35 or health benefits subject to state insurance regulation.

1 ~~"Carrier" does not include an organized delivery system.~~

2 Sec. 46. Section 513C.3, subsection 7, Code 2017, is amended
3 by striking the subsection.

4 Sec. 47. Section 513C.3, subsection 9, Code 2017, is amended
5 to read as follows:

6 9. "*Established service area*" means a geographic area,
7 as approved by the commissioner and based upon the carrier's
8 certificate of authority to transact business in this state,
9 within which the carrier is authorized to provide coverage ~~or~~
10 ~~a geographic area, as approved by the director and based upon~~
11 ~~the organized delivery system's license to transact business~~
12 ~~in this state, within which the organized delivery system is~~
13 ~~authorized to provide coverage.~~

14 Sec. 48. Section 513C.3, subsection 12, Code 2017, is
15 amended by striking the subsection.

16 Sec. 49. Section 513C.3, subsection 15, paragraph a,
17 subparagraph (3), Code 2017, is amended by striking the
18 subparagraph.

19 Sec. 50. Section 513C.3, subsection 18, Code 2017, is
20 amended to read as follows:

21 18. "*Restricted network provision*" means a provision of an
22 individual health benefit plan that conditions the payment
23 of benefits, in whole or in part, on the use of health care
24 providers that have entered into a contractual arrangement with
25 the carrier ~~or the organized delivery system~~ to provide health
26 care services to covered individuals.

27 Sec. 51. Section 513C.5, subsection 1, unnumbered paragraph
28 1, Code 2017, is amended to read as follows:

29 Premium rates for any block of individual health benefit
30 plan business issued on or after January 1, 1996, or the date
31 rules are adopted by the commissioner of insurance ~~and the~~
32 ~~director of public health~~ and become effective, whichever
33 date is later, by a carrier subject to **this chapter** shall be
34 limited to the composite effect of allocating costs among the
35 following:

1 Sec. 52. Section 513C.6, Code 2017, is amended to read as
2 follows:

3 **513C.6 Provisions on renewability of coverage.**

4 1. An individual health benefit plan subject to this
5 chapter is renewable with respect to an eligible individual or
6 dependents, at the option of the individual, except for one or
7 more of the following reasons:

8 a. The individual fails to pay, or to make timely payment
9 of, premiums or contributions pursuant to the terms of the
10 individual health benefit plan.

11 b. The individual performs an act or practice constituting
12 fraud or makes an intentional misrepresentation of a material
13 fact under the terms of the individual health benefit plan.

14 c. A decision by the individual carrier ~~or organized~~
15 ~~delivery system~~ to discontinue offering a particular type
16 of individual health benefit plan in the state's individual
17 insurance market. An individual health benefit plan may be
18 discontinued by the carrier ~~or organized delivery system~~ in
19 that market with the approval of the commissioner ~~or the~~
20 ~~director~~ and only if the carrier ~~or organized delivery system~~
21 does all of the following:

22 (1) Provides advance notice of its decision to discontinue
23 such plan to the commissioner ~~or director~~. Notice to the
24 commissioner ~~or director~~, at a minimum, shall be no less than
25 three days prior to the notice provided for in subparagraph (2)
26 to affected individuals.

27 (2) Provides notice of its decision not to renew such plan
28 to all affected individuals no less than ninety days prior
29 to the nonrenewal date of any discontinued individual health
30 benefit plans.

31 (3) Offers to each individual of the discontinued plan the
32 option to purchase any other health plan currently offered by
33 the carrier ~~or organized delivery system~~ to individuals in this
34 state.

35 (4) Acts uniformly in opting to discontinue the plan and

1 in offering the option under subparagraph (3), without regard
2 to the claims experience of any affected eligible individual
3 or beneficiary under the discontinued plan or to a health
4 status-related factor relating to any covered individuals or
5 beneficiaries who may become eligible for the coverage.

6 ~~d.~~ A decision by the carrier ~~or organized delivery system~~
7 to discontinue offering and to cease to renew all of its
8 individual health benefit plans delivered or issued for
9 delivery to individuals in this state. A carrier ~~or organized~~
10 ~~delivery system~~ making such decision shall do all of the
11 following:

12 (1) Provide advance notice of its decision to discontinue
13 such plan to the commissioner ~~or director~~. Notice to the
14 commissioner ~~or director~~, at a minimum, shall be no less than
15 three days prior to the notice provided for in subparagraph (2)
16 to affected individuals.

17 (2) Provide notice of its decision not to renew such plan
18 to all individuals and to the commissioner ~~or director~~ in each
19 state in which an individual under the discontinued plan is
20 known to reside, no less than one hundred eighty days prior to
21 the nonrenewal of the plan.

22 ~~e.~~ The commissioner ~~or director~~ finds that the continuation
23 of the coverage is not in the best interests of the
24 individuals, or would impair the carrier's ~~or organized~~
25 ~~delivery system's~~ ability to meet its contractual obligations.

26 2. At the time of coverage renewal, a carrier ~~or organized~~
27 ~~delivery system~~ may modify the health insurance coverage for
28 a policy form offered to individuals in the individual market
29 so long as such modification is consistent with state law and
30 effective on a uniform basis among all individuals with that
31 policy form.

32 3. An individual carrier ~~or organized delivery system~~ that
33 elects not to renew an individual health benefit plan under
34 subsection 1, paragraph "d", shall not write any new business in
35 the individual market in this state for a period of five years

1 after the date of notice to the commissioner ~~or director~~.

2 4. ~~This section~~, with respect to a carrier ~~or organized~~
3 ~~delivery system~~ doing business in one established geographic
4 service area of the state, applies only to such carrier's ~~or~~
5 ~~organized delivery system's~~ operations in that service area.

6 5. A carrier ~~or organized delivery system~~ offering coverage
7 through a network plan is not required to renew or continue in
8 force coverage or to accept applications from an individual who
9 no longer resides or lives in, or is no longer employed in,
10 the service area of such carrier ~~or organized delivery system~~,
11 or no longer resides or lives in, or is no longer employed
12 in, a service area for which the carrier is authorized to do
13 business, but only if coverage is not offered or terminated
14 uniformly without regard to health status-related factors of a
15 covered individual.

16 6. A carrier ~~or organized delivery system~~ offering coverage
17 through a bona fide association is not required to renew or
18 continue in force coverage or to accept applications from an
19 individual through an association if the membership of the
20 individual in the association on which the basis of coverage
21 is provided ceases, but only if the coverage is not offered or
22 terminated under this paragraph uniformly without regard to
23 health status-related factors of a covered individual.

24 7. An individual who has coverage as a dependent under a
25 basic or standard health benefit plan may, when that individual
26 is no longer a dependent under such coverage, elect to continue
27 coverage under the basic or standard health benefit plan if
28 the individual so elects immediately upon termination of the
29 coverage under which the individual was covered as a dependent.

30 Sec. 53. Section 513C.7, subsection 1, Code 2017, is amended
31 to read as follows:

32 1. a. ~~(1)~~ A carrier shall file with the commissioner, in
33 a form and manner prescribed by the commissioner, the basic
34 or standard health benefit plan. A basic or standard health
35 benefit plan filed pursuant to this paragraph may be used by

1 a carrier beginning thirty days after it is filed unless the
2 commissioner disapproves of its use.

3 ~~(2)~~ b. The commissioner may at any time, after providing
4 notice and an opportunity for a hearing to the carrier,
5 disapprove the continued use by a carrier of a basic or
6 standard health benefit plan on the grounds that the plan does
7 not meet the requirements of this chapter.

8 ~~b. (1) An organized delivery system shall file with the~~
9 ~~director, in a form and manner prescribed by the director,~~
10 ~~the basic or standard health benefit plan to be used by the~~
11 ~~organized delivery system. A basic or standard health benefit~~
12 ~~plan filed pursuant to this paragraph may be used by the~~
13 ~~organized delivery system beginning thirty days after it is~~
14 ~~filed unless the director disapproves of its use.~~

15 ~~(2) The director may at any time, after providing notice and~~
16 ~~an opportunity for a hearing to the organized delivery system,~~
17 ~~disapprove the continued use by an organized delivery system of~~
18 ~~a basic or standard health benefit plan on the grounds that the~~
19 ~~plan does not meet the requirements of this chapter.~~

20 Sec. 54. Section 513C.7, subsection 3, Code 2017, is amended
21 to read as follows:

22 3. A carrier ~~or an organized delivery system~~ shall not
23 modify a basic or standard health benefit plan with respect
24 to an individual or dependent through riders, endorsements,
25 or other means to restrict or exclude coverage for certain
26 diseases or medical conditions otherwise covered by the health
27 benefit plan.

28 Sec. 55. Section 513C.9, subsections 1, 2, 3, 6, and 8, Code
29 2017, are amended to read as follows:

30 1. A carrier, ~~an organized delivery system,~~ or an agent
31 shall not do either of the following:

32 a. Encourage or direct individuals to refrain from
33 filing an application for coverage with the carrier ~~or the~~
34 ~~organized delivery system~~ because of the health status, claims
35 experience, industry, occupation, or geographic location of the

1 individuals.

2 *b.* Encourage or direct individuals to seek coverage from
3 another carrier ~~or another organized delivery system~~ because of
4 the health status, claims experience, industry, occupation, or
5 geographic location of the individuals.

6 2. [Subsection 1](#), paragraph "*a*", shall not apply with respect
7 to information provided by a carrier ~~or an organized delivery~~
8 ~~system~~ or an agent to an individual regarding the established
9 geographic service area of the carrier ~~or the organized~~
10 ~~delivery system~~, or the restricted network provision of the
11 carrier ~~or the organized delivery system~~.

12 3. A carrier ~~or an organized delivery system~~ shall not,
13 directly or indirectly, enter into any contract, agreement, or
14 arrangement with an agent that provides for, or results in, the
15 compensation paid to an agent for a sale of a basic or standard
16 health benefit plan to vary because of the health status or
17 permitted rating characteristics of the individual or the
18 individual's dependents.

19 6. Denial by a carrier ~~or an organized delivery system~~ of an
20 application for coverage from an individual shall be in writing
21 and shall state the reason or reasons for the denial.

22 8. If a carrier ~~or an organized delivery system~~ enters into
23 a contract, agreement, or other arrangement with a third-party
24 administrator to provide administrative, marketing, or other
25 services related to the offering of individual health benefit
26 plans in this state, the third-party administrator is subject
27 to [this section](#) as if it were a carrier ~~or an organized~~
28 ~~delivery system~~.

29 Sec. 56. Section 513C.10, subsection 1, paragraph a, Code
30 2017, is amended to read as follows:

31 *a.* All persons that provide health benefit plans in this
32 state including insurers providing accident and sickness
33 insurance under [chapter 509](#), [514](#), or [514A](#), whether on an
34 individual or group basis; fraternal benefit societies
35 providing hospital, medical, or nursing benefits under chapter

1 512B; and health maintenance organizations, ~~organized delivery~~
2 ~~systems~~, other entities providing health insurance or health
3 benefits subject to state insurance regulation, and all other
4 insurers as designated by the board of directors of the Iowa
5 comprehensive health insurance association with the approval of
6 the commissioner shall be members of the association.

7 Sec. 57. Section 513C.10, subsection 2, paragraph a, Code
8 2017, is amended to read as follows:

9 a. Rates for basic and standard coverages as provided in
10 this chapter shall be determined by each carrier ~~or organized~~
11 ~~delivery system~~ as the product of a basic and standard factor
12 and the lowest rate available for issuance by that carrier ~~or~~
13 ~~organized delivery system~~ adjusted for rating characteristics
14 and benefits. Basic and standard factors shall be established
15 annually by the Iowa comprehensive health insurance association
16 board with the approval of the commissioner. Multiple basic
17 and standard factors for a distinct grouping of basic and
18 standard policies may be established. A basic and standard
19 factor is limited to a minimum value defined as the ratio
20 of the average of the lowest rate available for issuance and
21 the maximum rate allowable by law divided by the lowest rate
22 available for issuance. A basic and standard factor is limited
23 to a maximum value defined as the ratio of the maximum rate
24 allowable by law divided by the lowest rate available for
25 issuance. The maximum rate allowable by law and the lowest
26 rate available for issuance is determined based on the rate
27 restrictions under [this chapter](#). For policies written after
28 January 1, 2002, rates for the basic and standard coverages
29 as provided in [this chapter](#) shall be calculated using the
30 basic and standard factors and shall be no lower than the
31 maximum rate allowable by law. However, to maintain assessable
32 loss assessments at or below one percent of total health
33 insurance premiums or payments as determined in accordance
34 with [subsection 6](#), the Iowa comprehensive health insurance
35 association board with the approval of the commissioner may

1 increase the value for any basic and standard factor greater
2 than the maximum value.

3 Sec. 58. Section 513C.10, subsections 3, 4, 7, 8, 9, and 10,
4 Code 2017, are amended to read as follows:

5 3. Following the close of each calendar year, the
6 association, in conjunction with the commissioner, shall
7 require each carrier ~~or organized delivery system~~ to report
8 the amount of earned premiums and the associated paid losses
9 for all basic and standard plans issued by the carrier ~~or~~
10 ~~organized delivery system~~. The reporting of these amounts must
11 be certified by an officer of the carrier ~~or organized delivery~~
12 ~~system~~.

13 4. The board shall develop procedures and assessment
14 mechanisms and make assessments and distributions as required
15 to equalize the individual carrier ~~and organized delivery~~
16 ~~system~~ gains or losses so that each carrier ~~or organized~~
17 ~~delivery system~~ receives the same ratio of paid claims to
18 ninety percent of earned premiums as the aggregate of all
19 basic and standard plans insured by all carriers ~~and organized~~
20 ~~delivery systems~~ in the state.

21 7. The board shall develop procedures for distributing
22 the assessable loss assessments to each carrier ~~and organized~~
23 ~~delivery system~~ in proportion to the carrier's ~~and organized~~
24 ~~delivery system's~~ respective share of premium for basic and
25 standard plans to the statewide total premium for all basic and
26 standard plans.

27 8. The board shall ensure that procedures for collecting
28 and distributing assessments are as efficient as possible
29 for carriers ~~and organized delivery systems~~. The board may
30 establish procedures which combine, or offset, the assessment
31 from, and the distribution due to, a carrier ~~or organized~~
32 ~~delivery system~~.

33 9. A carrier ~~or an organized delivery system~~ may
34 petition the association board to seek remedy from writing a
35 significantly disproportionate share of basic and standard

1 policies in relation to total premiums written in this state
2 for health benefit plans. Upon a finding that a carrier ~~or~~
3 ~~organized delivery system~~ has written a disproportionate share,
4 the board may agree to compensate the carrier ~~or organized~~
5 ~~delivery system~~ either by paying to the carrier ~~or organized~~
6 ~~delivery system~~ an additional fee not to exceed two percent
7 of earned premiums from basic and standard policies for that
8 carrier ~~or organized delivery system~~ or by petitioning the
9 commissioner ~~or director, as appropriate,~~ for remedy.

10 10. ~~a.~~ The commissioner, upon a finding that the acceptance
11 of the offer of basic and standard coverage by individuals
12 pursuant to [this chapter](#) would place the carrier in a
13 financially impaired condition, shall not require the carrier
14 to offer coverage or accept applications for any period of time
15 the financial impairment is deemed to exist.

16 ~~b.~~ ~~The director, upon a finding that the acceptance of the~~
17 ~~offer of basic and standard coverage by individuals pursuant~~
18 ~~to [this chapter](#) would place the organized delivery system in a~~
19 ~~financially impaired condition, shall not require the organized~~
20 ~~delivery system to offer coverage or accept applications for~~
21 ~~any period of time the financial impairment is deemed to exist.~~

22 Sec. 59. Section 514A.3B, subsection 3, paragraph k, Code
23 2017, is amended by striking the paragraph.

24 Sec. 60. Section 514B.25A, Code 2017, is amended to read as
25 follows:

26 **514B.25A Insolvency protection — assessment.**

27 1. Upon a health maintenance organization ~~or organized~~
28 ~~delivery system~~ authorized to do business in this state and
29 ~~licensed by the director of public health~~ being declared
30 insolvent by the district court, the commissioner may levy an
31 assessment on each health maintenance organization ~~or organized~~
32 ~~delivery system~~ doing business in this state and ~~licensed by~~
33 ~~the director of public health, as applicable,~~ to pay claims
34 for uncovered expenditures for enrollees. The commissioner
35 shall not assess an amount in any one calendar year which is

1 more than two percent of the aggregate premium written by each
2 health maintenance organization ~~or organized delivery system~~.

3 2. The commissioner may use funds obtained through an
4 assessment under [subsection 1](#) to pay claims for uncovered
5 expenditures for enrollees of an insolvent health maintenance
6 organization ~~or organized delivery system~~ and administrative
7 costs. The commissioner, by rule, may prescribe the time,
8 manner, and form for filing claims under [this section](#). The
9 commissioner may require claims to be allowed by an ancillary
10 receiver or the domestic receiver or liquidator.

11 3. *a.* A receiver or liquidator of an insolvent health
12 maintenance organization ~~or organized delivery system~~ shall
13 allow a claim in the proceeding in an amount equal to uncovered
14 expenditures and administrative costs paid under [this section](#).

15 *b.* A person receiving benefits under [this section](#) for
16 uncovered expenditures is deemed to have assigned the rights
17 under the covered health care plan certificates to the
18 commissioner to the extent of the benefits received. The
19 commissioner may require an assignment of such rights by a
20 payee, enrollee, or beneficiary, to the commissioner as a
21 condition precedent to the receipt of such benefits. The
22 commissioner is subrogated to these rights against the assets
23 of the insolvent health maintenance organization ~~or organized~~
24 ~~delivery system~~ that are held by a receiver or liquidator of
25 a foreign jurisdiction.

26 *c.* The assigned subrogation rights of the commissioner and
27 allowed claims under [this subsection](#) have the same priority
28 against the assets of the insolvent health maintenance
29 organization ~~or organized delivery system~~ as those claims of
30 persons entitled to receive benefits under [this section](#) or for
31 similar expenses in the receivership or liquidation.

32 4. If funds assessed under [subsection 1](#) are unused
33 following the completion of the liquidation of an insolvent
34 health maintenance organization ~~or organized delivery system~~,
35 the commissioner shall distribute the remaining amounts, if

1 such amounts are not de minimis, to the health maintenance
2 organizations ~~or organized delivery systems~~ that were assessed.

3 5. The aggregate coverage of uncovered expenditures under
4 this section shall not exceed three hundred thousand dollars
5 with respect to one individual. Continuation of coverage
6 shall cease after the lesser of one year after the health
7 maintenance organization ~~or organized delivery system~~ is
8 terminated by insolvency or the remaining term of the contract.
9 The commissioner may provide continuation of coverage on a
10 reasonable basis, including, but not limited to, continuation
11 of the health maintenance organization ~~or organized delivery~~
12 ~~system~~ contract or substitution of indemnity coverage in a form
13 as determined by the commissioner.

14 6. The commissioner may waive an assessment of a health
15 maintenance organization ~~or organized delivery system~~ if such
16 organization ~~or system~~ is impaired financially or would be
17 impaired financially as a result of such assessment. A health
18 maintenance organization ~~or organized delivery system~~ that
19 fails to pay an assessment within thirty days after notice of
20 the assessment is subject to a civil forfeiture of not more
21 than one thousand dollars for each day the failure continues,
22 and suspension or revocation of its certificate of authority.
23 An action taken by the commissioner to enforce an assessment
24 under [this section](#) may be appealed by the health maintenance
25 organization ~~or organized delivery system~~ pursuant to chapter
26 17A.

27 Sec. 61. Section 514C.10, subsection 2, paragraph e, Code
28 2017, is amended by striking the paragraph.

29 Sec. 62. Section 514C.11, Code 2017, is amended to read as
30 follows:

31 **514C.11 Services provided by licensed physician assistants**
32 **and licensed advanced registered nurse practitioners.**

33 1. Notwithstanding [section 514C.6](#), a policy or contract
34 providing for third-party payment or prepayment of health or
35 medical expenses shall include a provision for the payment of

1 necessary medical or surgical care and treatment provided by
2 a physician assistant licensed pursuant to [chapter 148C](#), or
3 provided by an advanced registered nurse practitioner licensed
4 pursuant to [chapter 152](#) and performed within the scope of the
5 license of the licensed physician assistant or the licensed
6 advanced registered nurse practitioner if the policy or
7 contract would pay for the care and treatment if the care and
8 treatment were provided by a person engaged in the practice
9 of medicine and surgery or osteopathic medicine and surgery
10 under [chapter 148](#). The policy or contract shall provide that
11 policyholders and subscribers under the policy or contract may
12 reject the coverage for services which may be provided by a
13 licensed physician assistant or licensed advanced registered
14 nurse practitioner if the coverage is rejected for all
15 providers of similar services. A policy or contract subject
16 to [this section](#) shall not impose a practice or supervision
17 restriction which is inconsistent with or more restrictive than
18 the restriction already imposed by law.

19 2. [This section](#) applies to services provided under a policy
20 or contract delivered, issued for delivery, continued, or
21 renewed in this state on or after July 1, 1996, and to an
22 existing policy or contract, on the policy's or contract's
23 anniversary or renewal date, or upon the expiration of the
24 applicable collective bargaining contract, if any, whichever
25 is later. [This section](#) does not apply to policyholders or
26 subscribers eligible for coverage under Tit. XVIII of the
27 federal Social Security Act or any similar coverage under a
28 state or federal government plan.

29 3. For the purposes of [this section](#), third-party payment or
30 prepayment includes an individual or group policy of accident
31 or health insurance or individual or group hospital or health
32 care service contract issued pursuant to [chapter 509](#), [514](#), or
33 [514A](#), an individual or group health maintenance organization
34 contract issued and regulated under [chapter 514B](#), ~~an organized~~
35 ~~delivery system contract regulated under rules adopted by the~~

1 ~~director of public health,~~ or a preferred provider organization
2 contract regulated pursuant to [chapter 514F](#).

3 4. Nothing in [this section](#) shall be interpreted to require
4 an individual or group health maintenance organization,~~an~~
5 ~~organized delivery system,~~ or a preferred provider organization
6 or arrangement to provide payment or prepayment for services
7 provided by a licensed physician assistant or licensed advanced
8 registered nurse practitioner unless the physician assistant's
9 supervising physician, the physician-physician assistant team,
10 the advanced registered nurse practitioner, or the advanced
11 registered nurse practitioner's collaborating physician has
12 entered into a contract or other agreement to provide services
13 with the individual or group health maintenance organization,
14 ~~the organized delivery system,~~ or the preferred provider
15 organization or arrangement.

16 Sec. 63. Section 514C.13, subsection 1, paragraph h, Code
17 2017, is amended by striking the paragraph.

18 Sec. 64. Section 514C.13, subsection 2, Code 2017, is
19 amended to read as follows:

20 2. A carrier ~~or organized delivery system~~ which offers to
21 a small employer a limited provider network plan to provide
22 health care services or benefits to the small employer's
23 employees shall also offer to the small employer a point of
24 service option to the limited provider network plan.

25 Sec. 65. Section 514C.13, subsection 3, unnumbered
26 paragraph 1, Code 2017, is amended to read as follows:

27 A carrier ~~or organized delivery system~~ which offers to a
28 large employer a limited provider network plan to provide
29 health care services or benefits to the large employer's
30 employees shall also offer to the large employer one or more
31 of the following:

32 Sec. 66. Section 514C.14, subsections 1 and 3, Code 2017,
33 are amended to read as follows:

34 1. Except as provided under [subsection 2 or 3](#), a carrier,
35 as defined in [section 513B.2](#), ~~an organized delivery system~~

1 ~~authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established
 2 pursuant to [chapter 509A](#) for public employees, which terminates
 3 its contract with a participating health care provider,
 4 shall continue to provide coverage under the contract to a
 5 covered person in the second or third trimester of pregnancy
 6 for continued care from such health care provider. Such
 7 persons may continue to receive such treatment or care through
 8 postpartum care related to the child birth and delivery.
 9 Payment for covered benefits and benefit levels shall be
 10 according to the terms and conditions of the contract.

11 3. A carrier,~~organized delivery system,~~ or a plan
 12 established under [chapter 509A](#), which terminates the contract
 13 of a participating health care provider for cause shall not
 14 be liable to pay for health care services provided by the
 15 health care provider to a covered person following the date of
 16 termination.

17 Sec. 67. Section 514C.15, Code 2017, is amended to read as
 18 follows:

19 **514C.15 Treatment options.**

20 A carrier, as defined in [section 513B.2](#),~~an organized~~
 21 ~~delivery system authorized under 1993 Iowa Acts, ch. 158,~~
 22 ~~and licensed by the director of public health,~~ or a plan
 23 established pursuant to [chapter 509A](#) for public employees,
 24 shall not prohibit a participating provider from, or penalize a
 25 participating provider for, doing either of the following:

26 1. Discussing treatment options with a covered individual,
 27 notwithstanding the carrier's,~~organized delivery system's,~~ or
 28 plan's position on such treatment option.

29 2. Advocating on behalf of a covered individual within
 30 a review or grievance process established by the carrier,
 31 ~~organized delivery system,~~ or [chapter 509A](#) plan, or established
 32 by a person contracting with the carrier,~~organized delivery~~
 33 ~~system,~~ or [chapter 509A](#) plan.

34 Sec. 68. Section 514C.16, subsection 1, Code 2017, is
 35 amended to read as follows:

1 1. A carrier, as defined in [section 513B.2](#), ~~an organized~~
2 ~~delivery system authorized under 1993 Iowa Acts, ch. 158,~~
3 ~~and licensed by the director of public health,~~ or a plan
4 established pursuant to [chapter 509A](#) for public employees,
5 which provides coverage for emergency services, is responsible
6 for charges for emergency services provided to a covered
7 individual, including services furnished outside any
8 contractual provider network or preferred provider network.
9 Coverage for emergency services is subject to the terms and
10 conditions of the health benefit plan or contract.

11 Sec. 69. Section 514C.17, subsections 1 and 3, Code 2017,
12 are amended to read as follows:

13 1. Except as provided under [subsection 2 or 3](#), if a carrier,
14 as defined in [section 513B.2](#), ~~an organized delivery system~~
15 ~~authorized under 1993 Iowa Acts, ch. 158,~~ or a plan established
16 pursuant to [chapter 509A](#) for public employees, terminates its
17 contract with a participating health care provider, a covered
18 individual who is undergoing a specified course of treatment
19 for a terminal illness or a related condition, with the
20 recommendation of the covered individual's treating physician
21 licensed under [chapter 148](#) may continue to receive coverage for
22 treatment received from the covered individual's physician for
23 the terminal illness or a related condition, for a period of
24 up to ninety days. Payment for covered benefits and benefit
25 levels shall be according to the terms and conditions of the
26 contract.

27 3. Notwithstanding [subsections 1 and 2](#), a carrier,
28 ~~organized delivery system,~~ or a plan established under chapter
29 509A which terminates the contract of a participating health
30 care provider for cause shall not be required to cover health
31 care services provided by the health care provider to a covered
32 person following the date of termination.

33 Sec. 70. Section 514C.18, subsection 2, paragraph a,
34 subparagraph (6), Code 2017, is amended by striking the
35 subparagraph.

1 Sec. 71. Section 514C.19, subsection 7, paragraph a,
2 subparagraph (6), Code 2017, is amended by striking the
3 subparagraph.

4 Sec. 72. Section 514C.20, subsection 3, paragraph f, Code
5 2017, is amended by striking the paragraph.

6 Sec. 73. Section 514C.21, subsection 2, paragraph d, Code
7 2017, is amended by striking the paragraph.

8 Sec. 74. Section 514C.22, subsection 1, unnumbered
9 paragraph 1, Code 2017, is amended to read as follows:

10 Notwithstanding the uniformity of treatment requirements of
11 section 514C.6, a group policy, contract, or plan providing
12 for third-party payment or prepayment of health, medical, and
13 surgical coverage benefits issued by a carrier, as defined in
14 section 513B.2, ~~or by an organized delivery system authorized~~
15 ~~under 1993 Iowa Acts, ch. 158,~~ shall provide coverage benefits
16 for treatment of a biologically based mental illness if either
17 of the following is satisfied:

18 Sec. 75. Section 514C.22, subsection 6, Code 2017, is
19 amended to read as follows:

20 6. A carrier, ~~organized delivery system,~~ or plan
21 established pursuant to [chapter 509A](#) may manage the benefits
22 provided through common methods including, but not limited to,
23 providing payment of benefits or providing care and treatment
24 under a capitated payment system, prospective reimbursement
25 rate system, utilization control system, incentive system for
26 the use of least restrictive and least costly levels of care,
27 a preferred provider contract limiting choice of specific
28 providers, or any other system, method, or organization
29 designed to assure services are medically necessary and
30 clinically appropriate.

31 Sec. 76. Section 514C.25, subsection 2, paragraph a,
32 subparagraph (5), Code 2017, is amended by striking the
33 subparagraph.

34 Sec. 77. Section 514C.26, subsection 5, paragraph a,
35 subparagraph (6), Code 2017, is amended by striking the

1 subparagraph.

2 Sec. 78. Section 514C.27, subsection 1, unnumbered
3 paragraph 1, Code 2017, is amended to read as follows:

4 Notwithstanding the uniformity of treatment requirements
5 of [section 514C.6](#), a group policy or contract providing for
6 third-party payment or prepayment of health or medical expenses
7 issued by a carrier, as defined in [section 513B.2](#), ~~or by an~~
8 ~~organized delivery system authorized under 1993 Iowa Acts, ch.~~
9 ~~158~~, shall provide coverage benefits to an insured who is a
10 veteran for treatment of mental illness and substance abuse if
11 either of the following is satisfied:

12 Sec. 79. Section 514C.27, subsection 6, Code 2017, is
13 amended to read as follows:

14 6. A carrier, ~~organized delivery system~~, or plan
15 established pursuant to [chapter 509A](#) may manage the benefits
16 provided through common methods including but not limited to
17 providing payment of benefits or providing care and treatment
18 under a capitated payment system, prospective reimbursement
19 rate system, utilization control system, incentive system for
20 the use of least restrictive and least costly levels of care,
21 a preferred provider contract limiting choice of specific
22 providers, or any other system, method, or organization
23 designed to assure services are medically necessary and
24 clinically appropriate.

25 Sec. 80. Section 514C.29, subsection 2, paragraph e, Code
26 2017, is amended by striking the paragraph.

27 Sec. 81. Section 514C.30, subsection 2, paragraph e, Code
28 2017, is amended by striking the paragraph.

29 Sec. 82. Section 514E.1, subsection 6, paragraph k, Code
30 2017, is amended by striking the paragraph.

31 Sec. 83. Section 514E.1, subsection 17, Code 2017, is
32 amended by striking the subsection.

33 Sec. 84. Section 514E.2, subsection 1, paragraph a, Code
34 2017, is amended to read as follows:

35 a. All carriers ~~and all organized delivery systems licensed~~

1 ~~by the director of public health~~ providing health insurance or
2 health care services in Iowa, whether on an individual or group
3 basis, and all other insurers designated by the association's
4 board of directors and approved by the commissioner shall be
5 members of the association.

6 Sec. 85. Section 514E.2, subsection 2, paragraph a,
7 subparagraph (3), Code 2017, is amended to read as follows:

8 (3) Two members selected by the members of the association,
9 one of whom shall be a representative from a corporation
10 operating pursuant to [chapter 514](#) on July 1, 1989, or
11 any successor in interest, and one of whom shall be a
12 representative of ~~an organized delivery system~~ or an insurer
13 providing coverage pursuant to [chapter 509](#) or [514A](#).

14 Sec. 86. Section 514E.7, subsection 1, paragraph a,
15 subparagraphs (1) and (2), Code 2017, are amended to read as
16 follows:

17 (1) A notice of rejection or refusal to issue substantially
18 similar insurance for health reasons by one carrier ~~or~~
19 ~~organized delivery system~~.

20 (2) A refusal by a carrier ~~or organized delivery system~~ to
21 issue insurance except at a rate exceeding the plan rate.

22 Sec. 87. Section 514E.7, subsection 1, paragraph b, Code
23 2017, is amended to read as follows:

24 *b.* A rejection or refusal by a carrier ~~or organized delivery~~
25 ~~system~~ offering only stoploss, excess of loss, or reinsurance
26 coverage with respect to an applicant under paragraph "a",
27 subparagraphs (1) and (2), is not sufficient evidence for
28 purposes of [this subsection](#).

29 Sec. 88. Section 514E.9, Code 2017, is amended to read as
30 follows:

31 **514E.9 Rules.**

32 Pursuant to [chapter 17A](#), the commissioner ~~and the director~~
33 ~~of public health~~ shall adopt rules to provide for disclosure
34 by carriers ~~and organized delivery systems~~ of the availability
35 of insurance coverage from the association, and to otherwise

1 implement [this chapter](#).

2 Sec. 89. Section 514E.11, Code 2017, is amended to read as
3 follows:

4 **514E.11 Notice of association policy.**

5 Every carrier, including a health maintenance organization
6 subject to [chapter 514B](#) and ~~an organized delivery system~~,
7 authorized to provide health care insurance or coverage for
8 health care services in Iowa, shall provide a notice of the
9 availability of coverage by the association to any person
10 who receives a rejection of coverage for health insurance
11 or health care services, or a rate for health insurance or
12 coverage for health care services that will exceed the rate of
13 an association policy, and that person is eligible to apply
14 for health insurance provided by the association. Application
15 for the health insurance shall be on forms prescribed by the
16 association's board of directors and made available to the
17 carriers and ~~organized delivery systems~~ and other entities
18 providing health care insurance or coverage for health care
19 services regulated by the commissioner.

20 Sec. 90. Section 514F.5, Code 2017, is amended to read as
21 follows:

22 **514F.5 Experimental treatment review.**

23 1. A carrier, as defined in [section 513B.2](#), ~~an organized~~
24 ~~delivery system authorized under 1993 Iowa Acts, ch. 158~~, or a
25 plan established pursuant to [chapter 509A](#) for public employees,
26 that limits coverage for experimental medical treatment, drugs,
27 or devices, shall develop and implement a procedure to evaluate
28 experimental medical treatments and shall submit a description
29 of the procedure to the division of insurance. The procedure
30 shall be in writing and must describe the process used to
31 determine whether the carrier, ~~organized delivery system~~,
32 or [chapter 509A](#) plan will provide coverage for new medical
33 technologies and new uses of existing technologies. The
34 procedure, at a minimum, shall require a review of information
35 from appropriate government regulatory agencies and published

1 scientific literature concerning new medical technologies, new
2 uses of existing technologies, and the use of external experts
3 in making decisions. A carrier,~~organized delivery system,~~
4 or chapter 509A plan shall include appropriately licensed
5 or qualified professionals in the evaluation process. The
6 procedure shall provide a process for a person covered under
7 a plan or contract to request a review of a denial of coverage
8 because the proposed treatment is experimental. A review of
9 a particular treatment need not be reviewed more than once a
10 year.

11 2. A carrier,~~organized delivery system,~~ or chapter 509A
12 plan that limits coverage for experimental treatment, drugs, or
13 devices shall clearly disclose such limitations in a contract,
14 policy, or certificate of coverage.

15 Sec. 91. Section 514I.2, subsection 10, Code 2017, is
16 amended to read as follows:

17 10. "*Participating insurer*" means any entity licensed by the
18 division of insurance of the department of commerce to provide
19 health insurance in Iowa ~~or an organized delivery system~~
20 ~~licensed by the director of public health~~ that has contracted
21 with the department to provide health insurance coverage to
22 eligible children under this chapter.

23 Sec. 92. Section 514J.102, subsection 24, Code 2017, is
24 amended to read as follows:

25 24. "*Health carrier*" means an entity subject to the
26 insurance laws and regulations of this state, or subject
27 to the jurisdiction of the commissioner, including an
28 insurance company offering sickness and accident plans, a
29 health maintenance organization, a nonprofit health service
30 corporation, a plan established pursuant to chapter 509A
31 for public employees, or any other entity providing a plan
32 of health insurance, health care benefits, or health care
33 services. ~~"Health carrier" includes, for purposes of this~~
34 ~~chapter, an organized delivery system.~~

35 Sec. 93. Section 514J.102, subsection 29, Code 2017, is

1 amended by striking the subsection.

2 Sec. 94. Section 514K.1, subsection 1, unnumbered paragraph
3 1, Code 2017, is amended to read as follows:

4 A health maintenance organization, ~~an organized delivery~~
5 ~~system~~, or an insurer using a preferred provider arrangement
6 shall provide to each of its enrollees at the time of
7 enrollment, and shall make available to each prospective
8 enrollee upon request, written information as required by rules
9 adopted by the commissioner ~~and the director of public health~~.
10 The information required by rule shall include, but not be
11 limited to, all of the following:

12 Sec. 95. Section 514K.1, subsection 2, Code 2017, is amended
13 to read as follows:

14 2. The commissioner ~~and the director~~ shall annually publish
15 a consumer guide providing a comparison by plan on performance
16 measures, network composition, and other key information to
17 enable consumers to better understand plan differences.

18 Sec. 96. Section 514L.1, subsection 3, Code 2017, is amended
19 to read as follows:

20 3. *"Provider of third-party payment or prepayment of*
21 *prescription drug expenses"* or *"provider"* means a provider of an
22 individual or group policy of accident or health insurance or
23 an individual or group hospital or health care service contract
24 issued pursuant to [chapter 509](#), [514](#), or [514A](#), a provider of a
25 plan established pursuant to [chapter 509A](#) for public employees,
26 a provider of an individual or group health maintenance
27 organization contract issued and regulated under [chapter 514B](#),
28 ~~a provider of an organized delivery system contract regulated~~
29 ~~under rules adopted by the director of public health~~, a
30 provider of a preferred provider contract issued pursuant to
31 chapter 514F, a provider of a self-insured multiple employer
32 welfare arrangement, and any other entity providing health
33 insurance or health benefits which provide for payment or
34 prepayment of prescription drug expenses coverage subject to
35 state insurance regulation.

1 Sec. 97. Section 514L.2, subsection 1, paragraph a,
2 unnumbered paragraph 1, Code 2017, is amended to read as
3 follows:

4 A provider of third-party payment or prepayment of
5 prescription drug expenses, including the provider's agents or
6 contractors and pharmacy benefits managers, that issues a card
7 or other technology for claims processing and an administrator
8 of the payor, excluding administrators of self-funded employer
9 sponsored health benefit plans qualified under the federal
10 Employee Retirement Income Security Act of 1974, shall issue
11 to its insureds a card or other technology containing uniform
12 prescription drug information. The commissioner of insurance
13 shall adopt rules for the uniform prescription drug information
14 card or technology applicable to those entities subject to
15 regulation by the commissioner of insurance. ~~The director of~~
16 ~~public health shall adopt rules for the uniform prescription~~
17 ~~drug information card or technology applicable to organized~~
18 ~~delivery systems.~~ The rules shall require at least both of the
19 following regarding the card or technology:

20 Sec. 98. Section 521F.2, subsection 7, Code 2017, is amended
21 to read as follows:

22 7. "*Health organization*" means a health maintenance
23 organization, limited service organization, dental or vision
24 plan, hospital, medical and dental indemnity or service
25 corporation or other managed care organization licensed under
26 chapter 514, or 514B, ~~or 1993 Iowa Acts, ch. 158~~, or any other
27 entity engaged in the business of insurance, risk transfer,
28 or risk retention, that is subject to the jurisdiction of the
29 commissioner of insurance ~~or the director of public health.~~
30 "*Health organization*" does not include an insurance company
31 licensed to transact the business of insurance under chapter
32 508, 515, or 520, and which is otherwise subject to chapter
33 521E.

34 Sec. 99. 1993 Iowa Acts, chapter 158, section 4, is amended
35 to read as follows:

1 SEC. 4. EMERGENCY RULES. Pursuant to sections 17 and 2, and
2 3 of this Act, the commissioner of insurance ~~or the director of~~
3 ~~public health~~ shall adopt administrative rules under section
4 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph
5 "b", to implement the provisions of this Act and the rules
6 shall become effective immediately upon filing, unless a later
7 effective date is specified in the rules. Any rules adopted in
8 accordance with the provisions of this section shall also be
9 published as notice of intended action as provided in section
10 17A.4.

11 Sec. 100. REPEAL. Section 135.120, Code 2017, is repealed.

12 Sec. 101. REPEAL. 1993 Iowa Acts, chapter 158, section 3,
13 is repealed.

14 Sec. 102. CODE EDITOR'S DIRECTIVE. The Code editor shall
15 correct and eliminate any references to the term "organized
16 delivery system" or other forms of the term anywhere else in
17 the Iowa Code or Iowa Code Supplement, in any bills awaiting
18 codification, in this Act, and in any bills enacted by the
19 Eighty-seventh General Assembly, 2017 Regular Session, or any
20 extraordinary session.

EXPLANATION

22 The inclusion of this explanation does not constitute agreement with
23 the explanation's substance by the members of the general assembly.

24 This bill relates to programs and activities under the
25 purview of the department of public health (DPH).

26 Division I of the bill relates to program funding
27 flexibility and reporting.

28 The bill provides that if the amount of estimated moneys to
29 be received from certain liquor fees and retail beer permit
30 fees that is transferred to DPH annually for grants to counties
31 operating a substance abuse program exceeds grant requests,
32 in addition to using the remainder for grants to entities to
33 operate a substance abuse prevention program, DPH may also use
34 the remainder for activities and public information resources
35 that align with best practices for substance-related disorder

1 prevention.

2 The bill eliminates the requirement under Code section
3 135.11, subsection 31, that DPH report to the chairpersons and
4 ranking members of the joint appropriations subcommittee on
5 health and human services, the legislative services agency, the
6 legislative caucus staffs, and the department of management
7 within 60 calendar days of applying for or renewing a federal
8 grant which requires a state match or maintenance of effort
9 and has a value of over \$100,000, including a listing of
10 the federal funding source and the potential need for the
11 commitment of state funding in the present or future.

12 The bill amends Code section 135.150 to require DPH to report
13 annually rather than semiannually to the general assembly's
14 standing committees on government oversight regarding
15 the operation of the gambling treatment program including
16 information on the moneys expended and grants awarded for
17 operation of the program.

18 Division II of the bill relates to medical home and the
19 patient-centered health advisory council.

20 The bill amends provisions relating to medical homes.
21 Code sections 135.157 and 135.158, providing definitions and
22 describing the purposes and characteristics of medical homes,
23 are repealed by the bill. Code section 135.159 provides
24 parameters for the development and implementation of a medical
25 home system in the state, as well as the establishment of the
26 patient-centered health advisory council. The bill amends
27 Code section 135.159 to provide for the continuation of the
28 patient-centered health advisory council and to revise the
29 purposes of the council.

30 The bill also makes conforming changes throughout the Code,
31 including those relative to the definitions of "medical home",
32 "personal provider", and "primary medical provider", due to
33 elimination of certain definitions and concepts based upon the
34 repeal of Code sections 135.157 and 135.158.

35 Division III of the bill includes provisions relating to

1 workforce programming.

2 The bill amends Code section 135.107 relating to the center
3 for rural health and primary care. Of the programs that
4 constitute the primary care provider recruitment and retention
5 endeavor or PRIMECARRE, the bill eliminates the primary care
6 provider community scholarship program, but retains the primary
7 care loan repayment program and the community grant program
8 that is renamed the health care workforce and community support
9 grant program. The bill amends the application and matching
10 funds requirements for a grant under the health care workforce
11 and community support grant program and specifies that the
12 target areas for awarding of such grants are rural, underserved
13 areas or special populations identified by the department's
14 strategic plan or evidence-based documentation.

15 The bill provides that the primary care provider loan
16 repayment program may cancel a loan repayment program contract
17 for reasonable cause unless federal requirements otherwise
18 require and provides that the center for rural health and
19 primary care may enter into an agreement under Code chapter 28E
20 with the college student aid commission for administration of
21 the center's grant and loan repayment programs.

22 The bill eliminates the requirement that a community or
23 region applying for assistance under any of the programs
24 established under PRIMECARRE submit a letter of intent to
25 conduct a community health services assessment and instead
26 requires that the community or region shall document
27 participation in the community health services assessment. In
28 addition to any other requirements, an applicant's plan is
29 also to include, to the extent possible, a clear commitment to
30 informing high school students of the health care opportunities
31 which may be available to such students.

32 The bill removes the representation by the obsolete rural
33 health resource center on the advisory committee to the center
34 for rural health and primary care and corrects the reference to
35 a national or regional institute for rural health policy.

1 The bill eliminates the reference to "long-term care" in
2 Code section 135.163 which directs DPH to coordinate public and
3 private efforts to develop and maintain an appropriate health
4 care delivery infrastructure and a stable, well-qualified,
5 diverse, and sustainable health care workforce in this state.
6 Under this section, DPH is required, at a minimum, to develop
7 a strategic plan for health care delivery infrastructure and
8 health care workforce resources in this state; provide for
9 the continuous collection of data to provide a basis for
10 health care strategic planning and health care policymaking;
11 and make recommendations regarding the health care delivery
12 infrastructure and the health care workforce that assist
13 in monitoring current needs, predicting future trends, and
14 informing policymaking.

15 The bill amends Code section 135.175 relating to the health
16 care workforce support initiative, the workforce shortage fund,
17 and the accounts within the fund. The bill provides that
18 state programs that may receive moneys from the fund or the
19 accounts in the fund, if specifically designated for drawing
20 down federal funding, include PRIMECARRE, the Iowa affiliate
21 of the national rural recruitment and retention network, the
22 oral and health delivery systems bureau of the department,
23 the primary care office and shortage designation program, and
24 the state office of rural health, but eliminates inclusion of
25 the Iowa health workforce center, the area health education
26 centers programs at Des Moines university osteopathic medical
27 center and the university of Iowa, and the Iowa collaborative
28 safety net provider network as potential recipients. The bill
29 also eliminates the requirement that state appropriations to
30 the fund shall be allocated in equal amounts to each of the
31 accounts within the fund, unless otherwise specified in the
32 appropriation or allocation, and eliminates the restriction
33 that moneys in each of the accounts in the fund used for
34 administrative purposes are not to exceed \$100,000 in each
35 account, but retains the limitation that no more than 5 percent

1 of the moneys in any of the accounts within the fund shall be
2 used for administrative purposes unless otherwise provided in
3 the appropriation, allocation, or source of the funds.

4 The bill repeals Code section 135.164 which relates to the
5 health care delivery infrastructure and health care workforce
6 resources strategic plan to be developed by DPH including the
7 specific elements of the strategic plan and the requirements
8 for developing the strategic plan.

9 The bill repeals Code section 135.180, the mental health
10 professional shortage area program, which provides stipends to
11 support psychiatrist positions with an emphasis on securing and
12 retaining medical directors at community mental health centers
13 designated under Code chapter 230A and hospital psychiatric
14 units that are located in mental health professional shortage
15 areas.

16 Division IV of the bill relates to unfunded or outdated
17 program provisions.

18 The bill eliminates the provision under Code section 135.11
19 requiring DPH to establish and administer a substance abuse
20 treatment facility for persons on probation, repeals Code
21 section 135.130, and strikes the conforming provision in Code
22 section 901B.1. The substance abuse treatment facility for
23 persons on probation was authorized in 2001 but was never
24 established.

25 The bill strikes the directive in Code section 135.141 for
26 the division of acute disease prevention and emergency response
27 of DPH to conduct and maintain a statewide risk assessment
28 of any present or potential danger to the public health from
29 biological agents.

30 The bill repeals Code section 135.26 establishing the
31 automated external defibrillator (AED) grant program to provide
32 matching fund grants to local boards of health, community
33 organizations, or cities to implement AED programs.

34 The bill repeals Code section 135.29, relating to local
35 substitute medical decision-making boards, which authorized

1 each county to establish and fund a local substituted medical
2 decision-making board to act as a substitute decision maker for
3 patients incapable of making their own medical care decisions
4 if no other substitute decision maker is available to act.

5 The bill repeals Code section 135.120, relating to the
6 taxation of organized delivery systems (ODSs). 1993 Iowa
7 Acts, chapter 158, section 3, directs DPH to adopt rules and a
8 licensing procedure for the establishment of ODSs. The bill
9 only eliminates the provision for taxation of ODSs, not all
10 other provisions relating to ODSs.

11 The bill repeals Code section 135.152, the statewide
12 obstetrical and newborn indigent patient care program. The
13 program acts as a payer of last resort for eligible individuals
14 but has not been utilized since 2009 due to other options
15 for coverage including through the Medicaid program and the
16 Affordable Care Act for otherwise eligible individuals.

17 Division V includes miscellaneous provisions.

18 The bill amends the definition of "local board of health" in
19 Code section 135A.2 under the public health modernization Act
20 to be consistent with the definition under Code chapter 137,
21 relating to local boards of health.

22 The bill repeals Code section 135.132, the interagency
23 pharmaceuticals bulk purchasing council. The provision was
24 enacted in 2003, but the council was never established.

25 Division VI relates to the Iowa health information
26 network. Legislation was enacted in 2015 Iowa Acts, chapter
27 73, to provide for the future assumption of the Iowa health
28 information network by a designated entity. The bill
29 includes a conforming change that would take effect upon
30 future assumption of the Iowa health information network by a
31 designated entity.

32 Division VII relates to organized delivery systems that are
33 regulated by DPH. Organized delivery systems were created
34 pursuant to 1993 Iowa Acts, chapter 158. Rules adopted
35 under the provision define an organized delivery system as

1 "an organization with defined governance that is responsible
2 for delivering or arranging to deliver the full range of
3 health care services covered under a standard benefit plan
4 and is accountable to the public for the cost, quality and
5 access of its services and for the effect of its services
6 on their health." (641 IAC 201.2) An organization operating
7 as an organized delivery system is required to assume risk
8 and be subject to solvency standards. The bill eliminates
9 all references to organized delivery systems in the Code and
10 repeals the provision in the Acts authorizing the establishment
11 of organized delivery systems. The most recent application for
12 licensure was received by DPH in 1998. Since being authorized
13 in 1993, only two entities applied for licensure as organized
14 delivery systems and both of these entities have since ceased
15 operations.